From: [redacted] [redacted]
Sent: Saturday, 12 November 2016 12:40 AM
To: medboardconsultation
Subject: Revalidation - Submission

I have read the documents supplied by the Board in regard to the proposed process of revalidation, and am concerned by two aspects of the methods suggested.

Firstly, I am strongly opposed to the idea of selecting for extra scrutiny individuals who have not demonstrated any reason for suspicion that their standard of practice is defective, but who happen to fit into a category determined by factors such as age, gender or country of medical graduation. This to me is reminiscent of Mediaeval witchhunts, except that the typical victim will be not the elderly female herbalist living alone with cat, but rather the elderly male solo practitioner with "ethnic background". It suggests prejudice, and the possibility of injustice, humiliation, inequality and total lack of political correctness. It is bound to result in claims of unfairness and victimization.

Secondly, I have difficulty with the concept of peer review. For example, I am a surgical assistant, and, while my assisting or the results of my work is constantly under the observation of my professional seniors (i.e. surgeons), assistants do not observe each other, nor would their presence as observers be welcomed by surgeons, so I wonder how my peers can assess my capability. Only a surgeon can assess an assistant, and fortunately no surgeon will tolerate one who is inept. I imagine a similar problem would apply in the case of psychiatrists and other practitioners whose doctor/patient relationship is strictly of a confidential nature. There is also the possible problem, if the Board should seek the opinion of peers, that professional jealousy or personal factors may influence the response. The same could apply if co-workers were questioned, which would be extremely humiliating and perhaps professionally damaging, as It would suggest complaints or wrong-doing as the cause of the investigation, and a co-worker is not necessarily in a position to judge a doctor's competence For example, an impatient theatre nurse may describe me as slow, because I suture meticulously, believing that the patient's satisfaction with the scar is more important than saving a few minutes of theatre time. And while I believe it is very important to communicate in a reassuring and pleasant manner with patients pre-operatively, the patient is hardly in a position to judge my work.

There is also mention in the proposal of peer review of medical records. If this were to entail examination of patient records of other doctors, it would be a grave invasion of patient privacy.

I consider that any attempt to assess a doctor's competence and standards of practice should be based on evidence which is factual, and which will stand scrutiny and not be coloured by personal bias, or unwarranted suspicion, nor should the selection for review or investigation of any practitioner cause humiliation or the possibility of damaging rumour, innuendo, or erosion of patient confidence.

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